DEPARTMENT OF BENEFIT PAYMENTS

August 11, 1975

ALL COUNTY LETTER NO. 75-173

TO: ALL COUNTIES

SUBJECT: HEALTH INSURANCE INQUIRY MAILING

During August, all Medi-Cal beneficiaries with an other health coverage indicator who you added to the CID file since December, 1974, will be receiving a questionnaire from the Department's Health Recovery Bureau. The Department must obtain sufficient information to bill insurance carriers for health care services provided to Medi-Cal beneficiaries who have other health insurance coverage.

This is the first in a series of mailings which will be done on a quarterly basis. The expected volume for this and future mailings is approximately 40,000 Health Insurance Inquiry forms per quarter.

A copy of the Health Insurance Inquiry form is attached for your information. Instructions for completing the questionnaire are on the reverse side of the form. Should your office or a Medi-Cal beneficiary have any questions regarding the form, you may call the Health Recovery Bureau at this toll-free WATS Line telephone number, 1-800-952-5294.

Thank you for your assistance.

Sincerely,

D. Hansen

D. Jerome Hansen, Chief
Health Recovery Bureau

DJH/DP/clg (916) 445-0416

OBSOLETE

Superseded by ACL # 77-15

Issued 3-17-77

GEN 654 (2/75)

HEALTH INSURANCE INQUIRY

IMPORTANT: ***Please complete this form and return it AS SOON AS POSSIBLE in the enclosed postage-paid envelope. Return it even though you may have previously furnished this information. Follow the instructions on the reverse of this form. Be sure to examine all spaces provided and include all the information that is applicable. Write in all eligible family member names, Medi-Cal numbers and Social Security numbers not shown. If incorrect preprinted information appears on this form, line out the error(s) and supply the correct information, either above the error or on an attached piece of paper.***

IF YOU HAVE QUESTIONS ABOUT THIS FORM, CALL US — NO CHARGE TO YOU 1-800-952-5294.

SI NECESITA UD. MÁS INFORMACIÓN SOBRE ESTA FORMA, FAVOR DE TELEFONEAR 1-800-952-5294. NO LE CUESTA NADA A UD. SE HABLA ESPAÑOL.

I can be called by telephone at the following number: _____

1. ☐ Yes ☐ No While I/We have been on Medi-Cal, I/We have been covered by a health insurance policy.
2. ☐ Yes ☐ No I or a family member has a military connected disability. If Yes, name(s) of family member(s) _____
3. ☐ Yes ☐ No I or a family member is covered under a life care contract or trust. If Yes, name(s) of family member(s) _____
4. ☐ Yes ☐ No I or a family member needs or is receiving medical care due to an accident or injury for which another person or insurance company may be liable. If Yes, name(s) of injured family member(s) _____

	Health Insurance Information	First Policy	Second Policy (If any)
To be Completed if Yes to #1	5. Name and Address of Insurance Company		
	6. Name and Address of Policy Holder		
	7. Social Security Number of Policy Holder		
	FILL OUT ONLY THE SECTION BELOW THAT MATCHES YOUR TYPE OF POLICY		
PRIVATE POLICY	8. Policy Number		
POLICY THROUGH UNION	9. Union Name, Local Number and Address		
	10. Address of Employer		
	11. Policy Number		
POLICY THROUGH EMPLOYER	12. Name and Address of Employer		
	13. Policy Number		
	14. Group Number		
POLICY THROUGH GROUP	15. Name and Address of Group		
	16. Policy Number		
	17. Group Number		

This form is being sent to you because Medi-Cal records show that you have at some time either applied for Medi-Cal or were covered by Medi-Cal. The records also show that you may have had other health insurance coverage from a private or group health insurance plan which could pay for medical care which results from sickness or injury. California is now processing claims to recover funds from insurance companies where the Medi-Cal Program paid for medical services which should have been billed to other insurance plans. We would appreciate your cooperation by completing this form. Please use your insurance policy, membership card or any other aid to help you complete the questionnaire.

Item No. 1 Mark "Yes" if your health insurance policy covers one or more of the following services: hospital expenses, surgical expenses, routine medical expenses or major medical. Mark "No" if you or your family members never had a health insurance policy in effect while covered by Medi-Cal or if the insurance coverage was not health insurance – for example, life, automobile or burial insurance.

Item No. 2 Give the name(s) of any family member(s) that is or was covered by Medi-Cal and has a disability which is a result of military service.

Item No. 3 Give the name(s) of any family member(s) that is or was covered by Medi-Cal and is also covered by a contract that provides payment on medical expenses – for example, a will, an insurance settlement or a trust fund.

Item No. 4 Give the name(s) of any injured family member(s) that is or was covered by Medi-Cal and has an injury for which medical costs should be paid by someone else or an insurance company – for example, an injury at work, an injury at someone's home or an automobile accident where someone else was at fault.

Items No. 5–7 Complete this section for every policy regardless if it is a private policy, or through a union, employer or group.

Item No. 5 Current name and mailing address of the insurance company that provides or provided health insurance coverage for you or your family members.

Item No. 6 Full name and current mailing address of the person to whom the insurance policy is or was issued.

Item No. 7 Social Security Number of the person to whom the insurance policy is or was issued.

Items No. 8–17 Complete the section that matches the way you or your family member(s) obtained health insurance.

Items No. 8, 11, 13, 16 The number that the insurance company needs to identify the policy.

Item No. 9 Name, local number and address of the union local through which health insurance coverage was or is obtained – for example:

Bakers Union, Local No. 1
123 Main Street
Los Angeles, California 90071

Items No. 10, 12 Full name and current mailing address of the employer through which your health insurance is or was obtained.

Items No. 14, 17 The number that the insurance company assigned to your group to identify the policy, if any.

Item No. 15 Full name and current mailing address of the group through which your health insurance is or was obtained.